U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 09 January 2003

CASE NO. 2002-BLA-66

In the Matter of:

JUANITA R. PEVELER,
Claimant,

v.

PEABODY COAL CO.,
Employer,

and

OLD REPUBLIC INSURANCE CO.,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-interest

Appearances: Joseph H. Kelley, Esq.
For the Claimant

Philip J. Reverman, Jr., Esq.
For the Employer/Carrier

Before: Stephen L. Purcell
Administrative Law Judge

DECISION AND ORDER - DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act ("the Act"), 30 U.S.C. § 901, et seq. A formal hearing was held in Madisonville, Kentucky on August 8, 2002, at which all parties were afforded a full opportunity to present evidence and argument. Director's exhibits ("DX") 1-43, Director's exhibits on remand ("RDX") 2-3, and Employer's exhibits ("EX") 1-3 were admitted into evidence at the hearing. This decision is based upon an analysis of the record, the arguments of the parties, and the applicable law.

Background and History

Juanita R. Peveler ("Claimant") is the surviving spouse of Goodson J. Peveler ("Miner" or "Mr. Peveler") (DX43-1).[1] The Miner worked for thirty-six years in or around coal mines, as verified by the District Director, with the last year of coal mine employment occurring in Madisonville, Kentucky for the Employer (DX4, 5, 40).[2] Mr. Peveler died on December 30, 1998, and the Claimant filed for survivor's benefits under the Act on January 25, 1999 (DX1, 6). The District Director denied benefits on May 12, 1999 (DX21). The Claimant thereafter submitted additional medical records and urged reconsideration on June 3, 1999 (DX28). The District Director again denied benefits on July 23, 1999 (DX30). The Claimant requested a formal hearing on August 16, 1999, and the District Director transferred the claim to this office on August 16, 2000 (DX31).

On December 20, 2000, the Department substantively amended certain regulatory provisions at 20 C.F.R. Parts 718 and 725. In light of the uncertainty of the application of the new regulations and the preliminary injunction issued in *National Mining Association v. Chao*, No. 1:00 CV 03086 (EGS), Administrative Law Judge Robert L. Hillyard remanded this claim to the District Director (RDX2). The District Director referred the claim to this office again on October 23, 2001 (RDX3).

Issues Presented

The contested issues are:

1. Existence of pneumoconiosis.
2. Causal relationship of pneumoconiosis and coal mine employment.
3. Causation of death.

Elements of Entitlement

The Regulations at 20 C.F.R. Part 718 apply to all claims which are filed on or after April 1, 1980. 20 C.F.R. § 718.1. With respect to survivors' claims, any such claim filed on or after January 1, 1982, is governed by § 718.205(c) of the regulations. Because Ms. Peveler filed her survivor's claim after January 1, 1982, 20 C.F.R. § 718.205(c) applies to this claim.

The regulations provide that a survivor is entitled to benefits only where the miner died

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[1]DX43 is the Miner's claim, consisting of 398 pages and is referenced as DX43-(page number).

[2]The location where the claimant last engaged in coal mine employment determines which federal Court of Appeals has appellate jurisdiction. *Shupe v. Director, OWCP,* 12 B.L.R. 1-200, 1-202 (1989)(en banc). Therefore, the U. S. Court of Appeals for the Sixth Circuit has jurisdiction in this case.

due to pneumoconiosis. 20 C.F.R. § 718.205(a). The Claimant must establish that: (1) the decedent was a coal miner; (2) the decedent suffered from pneumoconiosis at the time of his death; (3) the decedent's pneumoconiosis arose out of his coal mine employment; and (4) the decedent's death was caused by pneumoconiosis or pneumoconiosis was a substantially contributing cause or factor leading to his death. All elements of entitlement must be established by a preponderance of the evidence. *Strike v. Director, OWCP,* 817 F.2d 395, 399 (7th Cir. 1987). The survivor of a miner who was totally disabled due to pneumoconiosis at the time of death, but died due to an unrelated cause, is not entitled to benefits. 20 C.F.R. § 718.205(c). If the principal cause of death is a medical condition unrelated to pneumoconiosis, the survivor is not entitled to benefits unless the evidence establishes that pneumoconiosis was a substantially contributing cause of the death. 20 C.F.R. § 718.205(c)(4).

The Board has held that death will be considered to be due to pneumoconiosis where the cause of death is significantly related to, or significantly aggravated by, pneumoconiosis. *Foreman v. Peabody Coal Co.*, 8 B.L.R. 1-371, 1-374 (1985). The United States Court of Appeals for the Third Circuit has held that any condition that hastens the miner's death is a substantially contributing cause of death for purposes of § 718.205. *Lukosevicz v. Director, OWCP*, 888 F.2d 1001 (3d Cir. 1989). The Fourth, Sixth, Seventh, and Tenth Circuits have adopted this position in *Shuff v. Cedar Coal Co.*, 967 F.2d 977 (4th Cir. 1992); *Brown v. Rock Creek Mining Corp.*, 996 F.2d 812 (6th Cir. 1993) (J. Batchelder dissenting); *Peabody Coal Co. v. Director, OWCP*, 972 F.2d 178 (7th Cir. 1992); and *Northern Coal Co. v. Director, OWCP*, 100 F.3d 871 (10th Cir. 1996) (a survivor is entitled to benefits if pneumoconiosis hastened the miner's death "to any degree").

The Board has held that, in a Part 718 survivor's claim, the Judge must make a threshold determination as to the existence of pneumoconiosis under 20 C.F.R. § 718.202(a) prior to considering whether the miner's death was due to the disease under § 718.205. *Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993).

Existence of Pneumoconiosis

Pneumoconiosis is defined, by regulation, as a "chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 20 C.F.R. § 718.201. The regulations at 20 C.F.R. § 718.203(b) provide that, if it is determined that the miner suffered from pneumoconiosis and has engaged in coal mine employment for ten years or more, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. If, however, it is established that the miner suffered from pneumoconiosis but worked less than ten years in the coal mines, then the claimant must establish causation by competent evidence. *Stark v. Director, OWCP,* 9 B.L.R. 1-36 (1986); *Hucker v. Consolidation Coal Co.,* 9 B.L.R. 1-137 (1986). The Board has held that the burden of proof is met under 718.203(c) where "competent evidence establish(es) that his pneumoconiosis is significantly related to or substantially aggravated by the dust exposure of his coal mine employment." *Shoup v. Director, OWCP,* 11 B.L.R. 1-1101-112 (1987). Specifically, the record

must contain *medical* evidence to demonstrate causation. *Baumgartner v. Director, OWCP*, 9 B.L.R. 1-65, 1-66 (1986)(administrative law judge cannot infer causation based solely upon claimant's employment history); *Tucker v. Director, OWCP*, 10 B.L.R. 1-35, 1-39 (1987) (it was error for the administrative law judge to rely solely upon lay testimony to find causation established).

The existence of pneumoconiosis may be established by any one or more of the following methods: (1) chest x-rays; (2) autopsy or biopsy reports; (3) the operation of a presumption; or (4) the opinion of a physician exercising sound medical judgment based on objective medical evidence. 20 C.F.R.§ 718.202(a).[3]

Medical Evidence

Medical records indicate diagnoses of hypertension, adenocarcinoma of the lung with cerebral metastasis, obesity, pneumonia, chronic obstructive pulmonary disease ("COPD"), pneumoconiosis, bronchitis, arteriosclerotic heart disease ("AHD"), neuralgia, gastritis, and duodenal ulcers (DX10-11, 20). Medical records further show that the Miner has a history of smoking about one pack of cigarettes per day for at least thirty-seven years (DX43-36).

Chest X-Rays

X-ray date	Re-read date	Physician	Qualifications	Film quality	Findings	Exhibit
06/14/78	06/14/78	Beck			No active disease	DX43-336
02/21/80	02/21/80	West			Moderate generalized increase bilaterally in pulmonary markings with nodular densities up to 7 mm in diameter occurring in several instances and numerous 2 to 3 mm nodules generally; massive amount of linear and nodular scar tissue in right lower lung field consistent with coal workers' pneumoconiosis	DX43-309

[3]The presumptions contained at §§ 718.304 - 718.306 are inapplicable in this case, and these methods of demonstrating pneumoconiosis will not be further discussed.

X-ray date	Re-read date	Physician	Qualifications	Film quality	Findings	Exhibit
03/27/80	06/26/80	Stokes			1/0[4,5]	DX43-295
03/27/80	07/23/82	Powell	BCR[6]		No active infiltrates and no masses; some increase in linear densities and nodularity consistent with Category 1 occupational pneumoconiosis	DX43-311
03/27/80	12/29/86	Pendergrass	BCR, B	1	0/0	DX43-10
12/18/80	12/18/80	Trover			Lungs are free of infiltrate and mass lesion; no evidence of COPD	DX43-54, 43-335
01/25/82	01/25/82	Long	A		1/1	DX43-304
01/25/82	01/25/82	Calhoun			Moderate generalized pulmonary emphysema bilaterally; interstitial bilateral pulmonary fibrotic process filled with medium sized nodules that are mainly round and measure from 1/5 mm to 3 mm; Category "II/II"	DX43-296

[4]The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1 / 2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2. Similarly, a reading of 0/0 means the doctor found no opacities and did not see any marks that would cause him or her to seriously consider category 1.

[5]There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, RESPIRATORY DISEASES 581 (3d ed. 1981).

[6]Physicians are identified in this table by last name followed by, where applicable, “BCR” for Board-certified Radiologist, “A” for A-Reader, “B” for B-Reader, and “C” for C-Reader. A designation of “Board-certified” means that the physician is “certified” in radiology or diagnostic roentgenology by the American Board of Radiology or the American Osteopathic Association. An “A-Reader” (also known as the “first” reader) is a physician, although not necessarily a radiologist, who has submitted six sample x-rays from his or her own files to the Appalachian Laboratory for Occupational Safety and Health (ALOSH) consisting of two x-rays negative for pneumoconiosis, two x-rays positive for simple pneumoconiosis, and two x-rays showing complicated pneumoconiosis. A “B-Reader” (also known as the “final” reader) is more qualified than an “A-Reader” and is a physician, but not necessarily a radiologist, who has successfully completed an examination in interpreting x-ray studies conducted by, or on behalf of, ALOSH. The “C-Reader” is the highest qualification available to an x-ray reader and is a closed classification. The designation of “C-reader” is used only to identify those highly regarded individuals who developed the widely used ILO-U/C classification system for classifying x-rays.

X-ray date	Re-read date	Physician	Qualifications	Film quality	Findings	Exhibit
01/25/82	08/06/82	Davis	BCR	2	1/0, Size 0	DX43-292-94
01/25/82	08/21/82	Payne	BCR, B	1	1/0, Size A	DX43-293
01/25/82	08/18/83	Cole	BCR, B	2	0/0	DX43-290
01/25/82	01/19/84	Elmer	BCR, B	2	Completely negative	DX43-289
03/08/82	03/11/82	Lieber	BCR	2	Completely negative	DX43-346
03/08/82	08/21/82	Cole	BCR, B	1	0/0	DX43-347
03/24/82	03/24/82	Anderson			Negative	DX43-119
03/24/82	05/10/82	Felson	BCR, C		Negative	DX43-185
03/24/82	05/28/82	Marshall	BCR, B		Negative	DX43-137
04/29/82	04/29/82	O'Neill			1/1	DX43-313
05/27/82	05/27/82	Coffman			Pneumoconiosis, Category 0; appearance does not suggest acute disease	DX43-55, 43-334
05/27/82	05/27/82	Gallo			No radiographic evidence of coal workers' pneumoconiosis	DX43-86
10/23/87	10/23/87	Stokes			Lung fields clear except for minimal fibrosis	DX11
11/08/88	11/08/88	Hicks			Some minimal linear fibrosis present; no infiltrates seen	DX10
02/10/95	02/10/95	Nein			Right lower lobe pneumonia	DX11
02/10/95	02/10/95	Jones			Streaky increased density in left lower lobe posteromedially consistent with pneumonitis	DX9, 11
02/10/95	04/12/99	Sargent	BCR, B	3	Negative	DX12
02/12/95	02/12/95	Galuten			Lungs hyperinflated, no significant change from 2/10/95 film	DX9, 11
02/12/95	04/12/99	Sargent	BCR, B	2	Negative	DX13
02/12/95	04/12/99	Sargent	BCR, B	3	Negative	DX14
01/27/97	01/27/97	Galuten			Apparent 2.5 cm oval mass within the left perihilar region; resolution of left lung base infiltrate compared with prior study	DX9, 11
01/27/97	04/12/99	Sargent	BCR, B	1	Negative	DX15
01/30/97	04/12/99	Sargent	BCR, B	3	Negative	DX16
02/03/97	04/12/99	Sargent	BCR, B	1	Negative	DX17
05/21/97	05/21/97	Murray			No new lesions, regression of adenocarcinoma tumor	DX10
11/19/97	11/19/97	Murray			Post-irradiation changes; fibrosis	DX10
02/18/98	02/18/98	Murray			No evidence of recurrent or progressive disease	DX10
02/18/98	02/18/98	King			Resolution of the previously observed malignancy in the left mid lung zone	DX20
05/20/98	05/20/98	Murray			No evidence of recurrent or new malignant disease	DX10
09/23/98	09/23/98	Long	A		Lungs clear; no pleural reaction; changes of interstitial disease	DX20
09/23/98	09/23/98	Murray			No significant change	DX10
12/12/98	12/21/98	Long	A		Pneumonitis cleared	DX20

X-ray date	Re-read date	Physician	Qualifications	Film quality	Findings	Exhibit
12/14/98	12/14/98	Murray			New left lobe infiltrate	DX20
12/15/98	12/15/98	Westmoreland			Bibasilar infiltrates present, most pronounced on the left	DX9, 11
12/15/98	04/12/99	Sargent	BCR, B	3	Negative	DX18
12/18/98	12/18/98	Westmoreland			Near total clearing in right lower lobe, partial clearing in left lower lobe compared with 12/15/98 film	DX9, 11
12/18/98	04/12/99	Sargent	BCR, B	3	Negative	DX19
12/22/98	12/22/98	King			Dobbhoff device placement satisfactory; lungs well expanded; mediastinum normal	DX20

Pulmonary Function Tests

The Miner's height was reported at sixty-nine inches in five of the eight pulmonary function tests, sixty-eight and one-half inches in one of the eight tests, and not reported in two of the tests. For purposes of determining the qualifying disability values, I find that the Miner's height equals 69 (sixty-nine) inches based on the majority of the pulmonary function test reports.

Date	Physician	Age	Height	FEV1	FVC	MVV	FEV1/FVC	Exhibit
03/08/82	Wright	62	68.5	1.82	2.08	66	88%	DX43-338
03/24/82	Anderson	62	NR	1.65	3.10	65.8	53%	DX43-365
04/29/82	O'Neill	62	69	1.63	2.61	44	62%	DX43-314
05/27/82	Gallo	62	69	1.57	2.82	36	56%	DX43-360
01/25/85	Pitzer	62	69	1.80	2.80	63	64%	DX43-297-303
11/29/88	Simpao (pre)	68	69	1.79	2.70	52	66%	DX10
11/29/88	Simpao (post)	68	69	1.86	2.78	66	67%	DX10
02/24/97	Haynes	77	NR	1.04	1.88		55%	DX28

Arterial Blood-Gas Tests

Date	Physician	pCO2	pO2	Exhibit
03/08/82	Wright (rest)	38.3	82.7	DX43-337
03/08/82	Wright (exercise)	39.7	87.1	DX43-337
03/24/82	Anderson	40.7	71.3	DX40-365
04/29/82	O'Neill	41.3	80.4	DX43-316
05/27/82	Gallo	39	71	DX40
02/10/95	Nein	33.7	61.8	DX11
01/27/97	Givens	39.1	58.4	DX11

Medical Opinion Evidence

Dr. William G. West, Jr., a general practitioner, examined the Miner on January 22, 1982 (DX43-309). The Miner reported over thirty-nine years of coal mine employment, all but one

year of which was above-ground in strip mines. The Miner's above-ground work occurred both out of the pits and around the tipple, and involved servicing tractors and working as a laborer in the bath house. Dr. West interpreted a February 21, 1980, x-ray as showing several nodular densities of up to seven millimeters in diameter, numerous two to three millimeter nodules generally, and linear and nodular scar tissue in the right lower lobe. Based on his examination and x-ray interpretation, Dr. West diagnosed coal workers' pneumoconiosis ("CWP") and concluded that the Miner was disabled to do the work of a coal miner, or any other work requiring similar physical exertion, due primarily to CWP.

Dr. Neal Calhoun, who is also a general practitioner, examined the Miner on January 25, 1982 (DX43-305). Mr. Peveler reported prior coal mine employment of over thirty-nine years which he described as: underground mine work at the tipple (for about seven and one-half years), strip mine work as a truck driver and in the bath house. The Miner also reported that he started smoking cigarettes at age twelve and continued to smoke one pack per day up to the day of the examination. Dr. Calhoun diagnosed CWP, category II/II and COPD, and, on the basis of the Miner's employment history, physical examination, chest x-ray[7], and pulmonary function study, Dr. Calhoun found the Miner disabled for coal mining or similar work because of his inability to breathe.

Dr. Ballard D. Wright, whose qualifications are not shown by the record, examined the Miner on March 8, 1982, noting a smoking history of a pack of cigarettes per day for thirty years and forty years of coal mine experience (DX43-350). Dr. Wright found no evidence of CWP but did diagnose AHD and mild COPD unrelated to coal mine employment.

Dr. William H. Anderson, a pulmonary specialist, examined the Miner on March 24, 1982 (DX43-105-129). The examination included a review of Mr. Peveler's history, a physical examination, an electrocardiogram, pulmonary function studies, arterial blood-gas studies, and chest x-rays. Dr. Anderson diagnosed AHD and pulmonary emphysema with moderate obstructive ventilatory defect, but not pneumoconiosis.

Dr. Benjamin Felson, a Board Certified Radiologist and a C-reader who helped develop the ILO-U/C classification system and train B-readers to interpret films for pneumoconiosis, interpreted a chest x-ray dated March 24, 1982, as revealing no evidence whatsoever of CWP or any other form of pneumoconiosis (DX43-185). He also saw no x-ray evidence of scarring in Mr. Peveler's lungs or of any emphysema (DX43-187-88). Dr. Felson believed that if silicosis or pneumoconiosis had not developed after the Miner's thirty-eight years of coal dust exposure, they were unlikely to develop in the future (DX43-189).

Dr. Richard P. O'Neill, a pulmonologist, examined Mr. Peveler on April 29, 1982 (DX43-312). The Miner reported working as an outside coal miner for over thirty-nine years and

[7]Dr. Calhoun refers to the chest x-ray performed by Pennyrile Radiology as indicating Category "II/II", whereas Dr. Larry Long, the radiologist who performed the x-ray, found Category 1/1.

that he smoked one pack of cigarettes daily for most of his adult life. Dr. O'Neill performed a physical examination, administered chest x-rays and pulmonary function studies, and diagnosed moderate small airways obstructive disease, chronic bronchitis, simple CWP, mild hypertension, and obesity. Dr. O'Neill based his diagnosis of simple CWP on the Miner's chronic inhalation of coal dust for thirty-nine years, and based his diagnosis of small obstructive airway disease primarily on Mr. Peveler's chronic cigarette smoking and, to a minor degree, on coal dust inhalation. Dr. O'Neill acknowledged that the Miner's effort on the pulmonary function study was "fair" at best, but despite that effort, he felt the Miner had a significant airway obstruction. It was also Dr. O'Neill's opinion that Mr. Peveler's CWP, in and of itself, caused no respiratory impairment, and that any respiratory dysfunction experienced by the Miner resulted from his small obstructive airway disease (DX43-209). Dr. O'Neill concluded that the Miner was incapable of engaging in heavy manual labor as a result of his respiratory impairment (DX43-210).

Dr. Thomas A. Gallo, a pulmonary specialist, evaluated Mr. Peveler on May 27, 1982 (DX43-73-99).[8] Dr. Gallo diagnosed COPD, bronchitis and emphysema on the basis of the Miner's employment history (one and one-half years underground, thirty-eight and one-half years driving a truck), smoking history of forty-two years, a physical examination, a chest x-ray, an EKG, pulmonary function tests, and arterial blood gas tests. The chest x-ray showed "no radiographic evidence of coal workers' pneumoconiosis" (DX43-82, 86). Based upon the chest x-ray and the Miner's limited coal dust exposure as a truck driver, Dr. Gallo attributed the Miner's pulmonary conditions to his smoking history of more than forty years, with coal mine employment as a minor factor.

Dr. L. H. Westmoreland, a radiologist, administered a CT scan of the Miner's chest on February 5, 1997 (DX11). Dr. Westmoreland noted a 2.2 centimeter rounded, fairly well defined soft tissue density abutting the pleura. He also noted scattered calcified granuloma within both lung fields with a small calcific density seen lying posterior and lateral to the soft tissue mass.

A November 24, 1997 CT scan of Mr. Peveler's chest by Dr. James C. King, showed a pleural base soft tissue abnormality in the left lower lobe posteriorly with some associated pulmonary parenchymal change extending to the left lung hilus. Dr. King diagnosed carcinoma of the lung.

Dr. Michael J. Murray, a radiation oncologist, noted a history of adenocarcinoma and administered radiation therapy beginning in early 1997 (DX10). Dr. Murray indicated a history of smoking a pack of cigarettes per day for fifty years, but further noted that the Miner ceased smoking in 1985 (DX10-11). According to Dr. Murray, the tumor in Mr. Peveler's lung regressed after the radiation therapy, but adenocarcinoma reappeared and metastasized in late 1998. Dr. Murray noted that an MRI scan showed a large lesion, approximately three to four centimeters in greatest dimension, in the frontal lobe area. Dr. Murray treated the Miner with cranial irradiation beginning in December 1998, but Mr. Peveler was unable to continue treatment

[8]Dr. Gallo's report appears in narrative form in his deposition transcript.

due to a pulmonary infiltrate.

Dr. Manoj H. Majmudar performed a bronchoscopy on Mr. Peveler on December 23, 1998 (DX20). Dr. Majmudar noted that the Miner's lobes were all within normal limits except for a large quantity of thick yellowish sputum, which was removed.

The Miner died on December 30, 1998 (DX6). Dr. Gary Givens indicated on the death certificate that adenocarcinoma of the lung with metastasis was the immediate cause of death. Other significant conditions noted on the death certificate as contributing to the death, but not resulting in the adenocarcinoma, included emphysema, hypertension, and COPD..

In a letter to Claimant's attorney dated May 25, 1999, Dr. Givens stated that he treated the Miner from February 1985 until his death and that during that time Mr. Peveler had severe COPD and pneumoconiosis (DX28). However, when deposed in connection with this claim on September 1, 1999, Dr. Givens acknowledged that he never personally diagnosed Mr. Peveler with pneumoconiosis until after the Miner's death (DX37). Dr. Givens's medical records reflect that he treated the Miner for bronchitis, COPD, borderline adult-onset diabetes, exogenous obesity, systolic hypertension, and pneumonia, but not pneumoconiosis. According to Dr. Givens, Mr. Peveler experienced frequent episodes of respiratory infections, including pneumonia and significant hypoxia, prior to the diagnosis of adenocarcinoma of the lung in February 1997. Dr. Givens concluded that the Miner's coal dust exposure was a factor in the production of COPD, but could not determine to what degree it contributed to that condition. He further acknowledged that the Miner's cigarette smoking alone could have produced the COPD. Dr. Givens concluded that the Miner's pre-existing pulmonary condition and his age prevented more aggressive treatment of the adenocarcinoma which could have extended Mr. Peveler's life.

Dr. P. Raphael Caffrey, a pathologist, authored a consultation report dated September 25, 2000, after reviewing Mr. Peveler's medical records (EX1). Dr. Caffrey opined that the Miner did not have CWP noting that it would be unusual for an individual to develop coal workers' pneumoconiosis where his coal mine employment consisted of one and one-half years underground and thirty-eight and one-half years above ground as a truck driver. He further noted that there were numerous negative chest x-rays and diagnoses by various physicians who did not find pneumoconiosis. Dr. Caffrey also noted that, although the Miner was diagnosed by Dr. O'Neill as having CWP, Dr. O'Neill stated that: CWP does not cause obstructive airway disease, the Miner suffered from small airways obstructive disease and chronic bronchitis; and Mr. Peveler's CWP caused no pulmonary impairment.

Dr. Ben V. Branscomb, who specializes in pulmonary and internal medicine, reviewed the Miner's medical records and issued a report setting forth his findings on October 4, 2000 (EX2). Dr. Branscomb found that the Miner's chest x-rays did not support a diagnosis of CWP, that the most recent pulmonary function studies were greatly influenced by Mr. Peveler's lung cancer, and that the arterial blood-gas tests showed no impairment until the Miner's admission to the hospital due to his lung cancer. Dr. Branscomb concluded that the Miner did not have CWP or any other

occupational lung disease associated with coal dust exposure. He further concluded that coal dust exposure did not contribute to the Miner's cancer, his COPD was caused by heavy smoking and was neither caused nor aggravated by exposure to coal dust, and Mr. Peveler's death was caused by an inexorably progressive carcinoma of the lung and would have occurred at the same time and in the same way whether he did or did not have COPD.

Dr. Gregory J. Fino, a pulmonary specialist and B-reader, reviewed the Miner's medical records and issued a report of his findings and conclusions on December 19, 2000 (EX3). Dr. Fino opined that the Miner did not suffer from any occupationally acquired pulmonary condition as a result of coal dust exposure. He based this opinion on the majority of negative chest x-rays, the lack of any qualifying pulmonary function studies, and normal blood-gas tests, with the exception of tests performed during a hospital stay after lung cancer was diagnosed. Dr. Fino noted that the small airway flow was more reduced than the large airway flow, which is consistent with obstruction due to cigarette smoking, not coal dust exposure. He further stated that, if COPD was present, it was caused by smoking rather than exposure to coal dust. Dr. Fino concluded that the Miner died as a result of lung cancer which had no causal relation to coal dust inhalation and that, due to the fatally advanced lung cancer with metastases to the brain, neither coal dust exposure nor COPD hastened the Miner's death.

Findings of Fact and Conclusions of Law

As noted above, the existence of pneumoconiosis may be established by chest x-rays, biopsy, autopsy, regulatory presumption, or a physician's reasoned medical opinion. *See* 20 C.F.R. § 718.202(a). There is no biopsy or autopsy evidence of record and no evidence that would satisfy the regulatory presumption at 20 C.F.R. § 718.304.

Chest X-ray Evidence

A review of the radiographic interpretation evidence reveals a conflict in opinion as to whether Mr. Peveler suffered from coal workers' pneumoconiosis. In such cases, numerous guidelines exist for evaluating the diverse interpretations. First, the actual number of interpretations favorable and unfavorable may be a factor. *Wilt v. Wolverine Mining Company*, 14 B.L.R. 1-70 (1990). At the same time, mechanical reliance on numerical superiority is not appropriate. *Akins v. Director, OWCP,* 958 F.2d 49 (4th Circuit 1992). Second, consideration may be given to the evaluating physicians' qualifications and training. *Dixon v. North Camp Coal*, 8 B.L.R. 1-344 (1985) and *Melink v. Consolidation Coal Company,* 16 B.L.R. 1-31 (1991). The interpretations from the doctors with the greater expertise may be accorded more evidentiary weight. *Taylor v. Director, OWCP*, 10 BRBS 449, BRB No. 77-610 BLA (1979). Third, because pneumoconiosis is a progressive and irreversible disease, it may be appropriate to accord greater weight to the most recent evidence of record, especially where a significant amount of time separates newer evidence from that evidence which is older. *See Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc); *Conn v. White Deer Coal Co.*, 862 F.2d 591 (6th Cir. 1988) (limiting application of the "later evidence" rule if later chest x-ray interpretations are

inconsistent with the progressive nature of pneumoconiosis). The qualifications of the doctor who provided the most recent evaluation may also bear on the evidentiary weight of the study. *McMath v. Director, OWCP*, 12 B.L.R. 1-6 (1988). Finally, when faced with multiple interpretations of numerous x-rays, an administrative law judge should first evaluate the conflicting interpretations of one x-ray to determine whether that particular x-ray is negative or positive. Then, the administrative law judge resolves the conflict between the x-rays in context to determine whether pneumoconiosis is present. *Copley v. Arch of West Virginia, Inc.*, Case No. 93-1940 (4th Circuit June 21, 1994)(unpublished).

The chest x-ray evidence contained in the record includes twenty-six x-rays resulting in forty-six interpretations ranging from completely negative to findings of "Category II/II" pneumoconiosis. I initially note that only eight of the forty-six interpretations found sufficient evidence in the x-rays to diagnose the existence of pneumoconiosis.[9] Of those eight positive findings, only two were made by board-certified radiologists. Another one of the eight was made by an A-reader, and only one was made by a dually certified physician.[10] Furthermore, the most recent of these eight positive interpretations relates to an x-ray dated April 29, 1982, over sixteen years prior to the Miner's death (DX43-313). In contrast, there are twenty-eight interpretations of eighteen *more recent* x-rays dated between May 27, 1982, and December 22, 1998, none of which support a diagnosis of pneumoconiosis. As explained below, when reviewed both chronologically and qualitatively, the x-ray evidence does not support a finding of pneumoconiosis.

The first x-ray of record is dated June 14, 1978, and was interpreted by Dr. J. L. Beck as showing no active disease (DX43-336). The x-ray thus fails to establish the presence of pneumoconiosis.

The next x-ray of record was taken February 21, 1980, and interpreted by Dr. William G. West, Jr., a general practitioner. According to Dr. West, this x-ray is "compatible with a diagnosis of coal workers' pneumoconiosis" (DX43-309). The interpretation, standing alone, would thus support a finding of pneumoconiosis. However, the findings of a number of highly qualified physicians regarding subsequent chest x-rays outweigh this evidence.

Dr. Stokes, a radiologist, and Dr. Powell, a board-certified radiologist, interpreted a March 27, 1980, chest x-ray as "1/0" and "consistent with Category 1 occupational pneumoconiosis," respectively. I note, however, that the interpretations of Drs. Stokes and Powell meet only the minimum requirements for a finding of pneumoconiosis and indicate that they both seriously considered a negative finding. *See* 20 C.F.R. § 718.102. In contrast, Dr.

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[9]The eight interpretations positive for pneumoconiosis were rendered by Drs. West (DX43-309), Stokes (DX43-295), Powell (DX43-311), Long (DX43-304), Calhoun (DX43-296), Davis (DX43-292-94), Payne (DX43-293), and O'Neill (DX43-313).

[10]A "dually certified" physician is board-certified in radiology and a qualified B-Reader.

Pendergrass, who is both a board-certified radiologist and a B-Reader, interpreted the same x-ray as negative for pneumoconiosis ("0/0"). Because Drs. Stokes and Powell seriously considered negative findings and found the x-ray demonstrated only the minimal requirements for a positive finding, and because Dr. Pendergrass's interpretation is entitled to greater weight, I find that this x-ray fails to establish the presence of pneumoconiosis.

According to Dr. P.C. Trover, a December 18, 1980, chest x-ray showed the lungs were free of infiltrate and mass lesions, and revealed no evidence of COPD, or pleural or bony abnormalities (DX43-54, 335). This x-ray thus does not support a finding of pneumoconiosis.

There are six interpretations of the January 25, 1982, chest x-ray (DX43-290, 292-94, 296, 304). Four of these interpretations were positive for pneumoconiosis while two were negative. Given that five of the interpreting physicians are either A-readers board-certified radiologists, or dually certified, I accord little weight to the interpretation of Dr. Calhoun, a generalist, who concluded the x-ray revealed "Category II/II" pneumoconiosis. Furthermore, the three remaining positive interpretations meet only the minimum requirements for a finding of pneumoconiosis, while the interpretations rendered by Drs. Cole and Elmer, two dually certified physicians, were completely negative for pneumoconiosis. In light of the superior qualifications of Drs. Cole and Elmer, and the minimal findings consistent with pneumoconiosis found by the other three physicians, I find the January 25, 1982, x-ray is insufficient to establish the existence of pneumoconiosis.

Of the remaining thirty-four interpretations, only one, an April 29, 1982, x-ray, would support a finding of pneumoconiosis (DX43-313).[11] Dr. O'Neill, the physicians who interpreted this x-ray as positive for pneumoconiosis, is neither board-certified nor a B-reader. In contrast, all of the remaining thirty-three interpretations, each of which relates to x-rays that post-date the x-ray evaluated by Dr. O'Neill, either fail to indicate pneumoconiosis or specifically find the chest x-rays are negative for pneumoconiosis. Most notably, Dr. Sargent, who is dually certified, interpreted eight of these x-rays as negative (DX12-DX19). Accordingly, I find that the Claimant has failed to establish the existence of pneumoconiosis because the only positive chest x-ray findings are contradicted by more recent and more certain interpretations rendered by highly qualified physicians.

Medical Opinion Evidence

A determination of the existence of pneumoconiosis may also be made notwithstanding a negative x-ray if a physician, exercising sound medical judgment, finds that the miner suffers from pneumoconiosis. *See* 20 C.F.R. § 718.202(a)(4). The medical opinion must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms,

[11]A May 27, 1982, chest x-ray was interpreted by Dr. S. L. Coffman as showing "Category O" pneumoconiosis (DX43-55). However, such an interpretation demonstrates, at most, only a negligible presence of the disease and does not support a finding of pneumoconiosis under the Act or regulations.

pulmonary function studies, physical performance tests, physical examinations, and medical and work histories.

In a report dated January 25, 1982, Dr. Neal Calhoun diagnosed total disability due to pneumoconiosis on the basis of thirty-nine years of coal dust exposure, a smoking history of one pack of cigarettes per day since age twelve, a physical examination, a chest x-ray, and a pulmonary function test, all of which were administered on January 25, 1982 (DX43-305). Similarly, in a report dated February 2, 1982, Dr. William West diagnosed pneumoconiosis based on a January 22, 1982, physical examination of Mr. Peveler, a history of thirty-nine years and four months coal mine employment, a smoking history of one pack of cigarettes per day since age twelve, and a chest x-ray dated February 21, 1980 (DX43-309). I attribute little weight to their opinions, however, for several reasons. First, Dr. Calhoun and Dr. West are both general practitioners, and there is no evidence in the record to suggest that either physician possesses any particular expertise with respect to diagnosing or treating pulmonary or respiratory disorders associated with coal dust exposure. Second, both Dr. West and Dr. Calhoun expressly rely on positive x-ray findings of pneumoconiosis which, as noted above, are contradicted by numerous interpretations of more highly qualified physicians. Finally, as detailed below, a number of more highly qualified physicians who have also examined the miner, who have reviewed the results of various objective medical tests, and who are familiar with Mr. Peveler's work and smoking history, offer more coherent opinions negating the existence of pneumoconiosis.

Dr. Wright examined the Miner on March 8, 1982, and diagnosed COPD and arteriosclerotic heart disease (DX43-350). However, he expressly determined that Mr. Peveler's COPD was unrelated to coal dust exposure. His opinion was based upon approximately forty years of coal mine employment, thirty years of smoking about a pack of cigarettes daily, and a physical examination. Although Dr. Wright's opinion negating the existence of pneumoconiosis is based on limited objective medical evidence, and his qualifications are not of record, the opinion is corroborated by the overwhelming opinion evidence of other highly qualified physicians.

Dr. William Anderson, who is a pulmonary specialist, opined that the Miner suffered from pulmonary emphysema with moderate obstructive ventilatory defect, but not pneumoconiosis (DX43-105-129). His opinion is based upon a physical examination of the Miner conducted on March 24, 1982, the Miner's reported work history and smoking history, an electrocardiogram, a pulmonary function study, an arterial blood-gas study, and a chest x-ray, all of which were administered at the time of the examination. During a May 14, 1982, deposition in this case, Dr. Anderson explained that he did not detect any evidence of nodulation in the Miner's chest x-ray sufficient to diagnose pneumoconiosis (DX43-119). He further explained that the Miner's reported shortness of breath was related to his pulmonary emphysema, which was due to smoking a pack of cigarettes daily since the age of fifteen, and/or his AHD (DX43-120). I accord greater weight to Dr. Anderson's finding because he is a pulmonary specialist, his opinion is well reasoned, and the opinion is based on a thorough medical examination, which included various objective medical tests and was conducted expressly for the purpose of determining the presence

of CWP.

Dr. Richard O'Neill, who is also a pulmonologist, diagnosed moderate small airways obstructive disease, chronic bronchitis, simple CWP, mild hypertension, and obesity. He based his opinion upon Mr. Peveler's employment and smoking history, and his examination of the Miner on April 29, 1982, during which he administered a chest x-ray and pulmonary function study (DX43-312). The only explanation Dr. O'Neill offered for his diagnosis of CWP was "[b]ilateral reticulo-nodular infiltrate consistent with coal worker's pneumoconiosis, simple, state 1/1 (p and q)" (DX43-313). I find Dr. O'Neill's opinion is not well reasoned and therefore entitled to little weight. His interpretation of the April 29, 1982, chest x-ray is contradicted by the interpretations of several more highly qualified physicians relating to multiple chest x-rays which post-date the April 29, 1982, x-ray, as well as the interpretation of Dr. Anderson relating to a chest x-ray taken only a month before. In addition, Dr. O'Neill's medical opinion is contrary to the better-reasoned opinions of several physicians, including that of Dr. Anderson, all of whose qualifications are either equal to, or greater than, the qualifications of Dr. O'Neill.

Dr. Thomas Gallo, a pulmonary specialist, examined Mr. Peveler on May 27, 1982, and diagnosed COPD, bronchitis and emphysema (DX43-73-99). He based his diagnoses on the Miner's employment and smoking history, a physical examination, a chest x-ray, an EKG, a pulmonary function study, and an arterial blood gas test. Dr. Gallo testified during a July 9, 1982, deposition that he found no evidence of CWP in the chest x-ray. He further stated that, when compared to the Miner's substantial smoking history, Mr. Peveler's limited coal dust exposure as a truck driver was only "a minor factor, if any" in relation to his pulmonary impairment (DX43-86-87, 89-90, 96). Dr. Gallo's opinion is based on objective medical evidence, and I find it well reasoned. I further note that, to qualify under the legal definition of pneumoconiosis, a miner's pulmonary condition must be "significantly related to, or substantially aggravated by, [coal] dust exposure." 20 C.F.R. § 718.201(b). Thus, Dr. Gallo's opinion that Mr. Peveler's coal dust exposure was, at most, a minor factor in causing or aggravating his pulmonary condition is contrary to a finding of "legal pneumoconiosis."

Dr. Gary Givens, the Miner's treating physician, opined on May 25, 1999, that Mr. Peveler suffered from COPD and pneumoconiosis (DX28). Dr. Givens based his opinion on his treatment of the Miner, his review of other medical records, and the Miner's thirty to forty years of coal mine employment. Although the opinion of a treating physician may sometimes be accorded greater weight than the opinions of other physicians, I decline to do so in this case. As noted previously, Dr. Givens testified during his September 1, 1999, deposition that he first began seeing the Miner in February 1985 and, although he diagnosed and treated Mr. Peveler for a variety of illnesses including COPD, bronchitis, diabetes, obesity, hypertension, and adenocarcinoma of the lung, he never diagnosed Mr. Peveler with pneumoconiosis at any time prior to the Miner's death (DX38). Indeed, Dr. Givens' medical records during the fourteen years he treated the Miner do not once mention such a diagnosis. It was not until he wrote to Mr. Peveler's attorney on May 25, 1999, after the Miner's death, that Dr. Givens first mentions pneumoconiosis as a condition for which he treated Mr. Peveler. Furthermore, Dr. Givens could

not estimate to what degree coal dust may have contributed to Mr. Peveler's COPD (indicating that he was relying on the statistics of coal miners in general), and he testified that the Miner's respiratory condition could have been produced by cigarette smoking alone. I thus find Dr. Givens' opinion to be not well reasoned and contrary to the opinions of several more highly qualified physicians.

Dr. Raphael Caffrey, a pathologist, authored a consultative report dated September 25, 2000, in which he opined that Mr. Peveler did not have CWP. He based his opinion upon a review of, *inter alia*, the Miner's medical records, the deposition testimony of Drs. Anderson, Gallo, O'Neill, and Givens, and the Miner's death certificate. According to Dr. Caffrey, the many medical documents that he reviewed failed to reveal "the necessary findings to make a diagnosis of coal worker's pneumoconiosis or any other occupational pneumoconiosis" (EX1). He noted particularly that his opinion was supported by the negative opinion of Dr. Anderson, who examined the Miner approximately two months after his retirement from mining, by the opinion of Dr. Sargent, a Board-certified Radiologist and B-Reader, who found no evidence of pneumoconiosis after reviewing eight chest x-rays dated from 1995 to 1998, and by the lack of any recorded treatment of the Miner by Dr. Givens for pulmonary problems during a five year period beginning in 1990. According to Dr. Caffrey, Mr. Peveler's pulmonary problems, consisting of emphysema, bronchitis, and the adenocarcinoma which ultimately led to his death, were all attributable to the Miner's history of smoking approximately one pack of cigarettes daily for over forty years. I find Dr. Caffrey's opinion is well reasoned and consistent with the bulk of the objective medical evidence.

Dr. Ben Branscomb, who specializes in both pulmonary and internal medicine, authored an October 4, 2000, report in which he opined to "a high level of medical certainty or probability" that the Miner did not have CWP or any other occupational lung disease associated with coal dust exposure (EX2). His opinion was based on a review of medical records, reports, and/or deposition testimony by Drs. West, Calhoun, Anderson, Givens, Gallo, Lamar, Murray, and Hargrove. According to Dr. Branscomb, Mr. Peveler's death in December 1998 was caused by his rapidly spreading adenocarcinoma which was in no way caused or aggravated by coal dust exposure. He further concluded that the Miner's death was inevitable and would have occurred at the same time and in the same way whether he did or did not have COPD. I find Dr. Branscomb's opinion is consistent with the opinions of other highly qualified physicians, is well reasoned, and is based upon a thorough review of the medical evidence of record.

Dr. Gregory Fino specializes in internal medicine, with a subspecialty in pulmonary diseases. He is also a certified B-Reader and has authored a variety of publications relating to pulmonary impairments. Dr. Fino reviewed the Miner's history and all available medical records, and, in a report dated December 19, 2000, opined that the Miner did not suffer from any occupationally acquired pulmonary condition as a result of coal dust exposure (EX3). His conclusion is expressly based on: the majority of the chest x-ray readings in Mr. Peveler's file which were negative for pneumoconiosis; the lack of any valid pulmonary function studies in the record; spirometric evaluations which revealed small airway flow obstructions inconsistent with

coal dust exposure but consistent with cigarette smoking, pulmonary emphysema, non-occupational chronic bronchitis, and asthma; the lack of any impairment in oxygen transfer shown by blood gas studies; and normal lung volume values and diffusion capacity. The only abnormal blood gas reading contained in the record, according to Dr. Fino, was a February 10, 1995, test administered when the Miner was hospitalized for pneumonia, a condition which he determined bears no causal relationship to Mr. Peveler's coal mine employment. Dr. Fino wrote that, "[b]ased on the information which I have reviewed, I find no objective evidence prior to the development of this man's lung cancer that there was any evidence of a respiratory impairment or a pulmonary disability." He further noted that if COPD was present, it was caused by smoking, not exposure to coal dust. I find Dr. Fino's opinion is well reasoned, based on a thorough review of the medical evidence of record, and consistent with the opinions of other highly qualified physicians.

The medical opinion evidence taken as a whole fails to establish the existence of pneumoconiosis. Out of the ten medical opinions contained in the record, six conclude that Mr. Peveler did not have pneumoconiosis, while only four concluded that he did. The qualifications of the physicians who determined that the miner did not suffer from pneumoconiosis, particularly Drs. Anderson, Branscomb, and Fino, are superior to the qualifications of those physicians who rendered contrary opinions. Furthermore, their opinions are based on a review of the bulk of the medical evidence of record, including those records relating to the Miner's terminal illness, and are well reasoned. I therefore find that there is insufficient evidence linking the Miner's pulmonary disease to coal dust exposure. Accordingly, I find that the Claimant has failed to establish the existence of pneumoconiosis.

Causation of Death

As noted above, the Board has held that death will be considered to be due to pneumoconiosis where the cause of death is significantly related to, or significantly aggravated by, pneumoconiosis. *Foreman v. Peabody Coal Co.*, 8 B.L.R. 1-371, 1-374. Any condition that hastens the miner's death is a substantially contributing cause of death for purposes of § 718.205. *Brown v. Rock Creek Mining Corp.*, 996 F.2d 812.

Even if the Miner were shown to have suffered from pneumoconiosis, which is not the case, the overwhelming medical evidence of record indicates that he died due to lung cancer which was neither significantly related to, nor significantly aggravated by, pneumoconiosis. The only basis the Claimant offers in support of her theory that the Miner's pulmonary condition hastened his death is that it prevented more aggressive treatment of his adenocarcinoma. According to Dr. Givens, Mr. Peveler's treating physician, had the Miner not had any pulmonary impairment, he would likely have lived longer because he could have undergone surgery to remove the cancer from his lungs instead of relying solely on radiation therapy to treat that condition (DX37). Dr. Givens further testified, however, that even if Mr. Peveler had undergone surgery, his adenocarcinoma of the lungs could have recurred and metastasized as it did without surgery.

No physician who has reviewed the existing medical records, other than Dr. Givens, suggests that more aggressive treatment, whether surgery, chemotherapy, or radiation therapy, would have extended the Miner's life. On the contrary, highly qualified physicians who have looked at the medical evidence state just the opposite, i.e., that the Miner would have died at the same time and in the same manner regardless of his pulmonary condition. For example, Dr. Branscomb, who is a Distinguished Professor Emeritus of the University of Alabama at Birmingham and specializes in pulmonary and internal medicine, wrote that Mr. Peveler's death "was caused by an inexorably progressive carcinoma of the lung with widespread metastases including a huge one in the brain . . . [which] was in no way caused nor aggravated by coal dust exposure nor, if I assume he had CWP, by such CWP." (EX2). Dr. Branscomb concluded that the Miner's respiratory impairment did not hasten his death, explaining that "his death was inevitable and would have occurred at the same time in the same way whether he did or did not have COPD." Similarly, the December 19, 2000, report of Dr. Gregory Fino notes that Mr. Peveler "died as a result of lung cancer . . . [which] was neither caused nor contributed to by the inhalation of coal mine dust. He would have died as and when he did had he never stepped foot in the mines." (EX3). The opinions of Drs. Branscomb and Fino are supported by the medical evidence of record, are well reasoned, and establish that Mr. Peveler's death was unrelated to his coal mine employment.

CONCLUSION

I find that the Claimant has not established the existence of pneumoconiosis by a preponderance of the evidence. I also find that, even if the Claimant had established the existence of pneumoconiosis, and that such pneumoconiosis was caused by coal mine employment, she has failed to establish that pneumoconiosis caused the Miner's death, or was a substantially contributing cause or factor leading to his death. Accordingly, Ms. Peveler's claim for survivor's benefits is denied.

Attorney's Fee

The award of an attorney's fee is permitted only in cases in which the Claimant is found to be entitled to benefits. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for legal services rendered in pursuit of the claim.

ORDER

The Claimant's claim for federal black lung benefits is hereby denied.

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STEPHEN L. PURCELL
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Order may appeal it to the Benefits Review Board within 30 days from the date of this Order by filing a Notice of Appeal with the Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Francis Perkins Building, Room N-2605, 200 Constitution Avenue, N.W. Washington, D.C. 20210.